California Commission
on
Health and Safety and Workers' Compensation

MINUTES OF MEETING

Meeting Day and Date: Thursday, February 20, 1997

Meeting Location: State Office Building
107 South Broadway
First Floor Auditorium, Room 1138
Los Angeles, California

Commission Members Present:

Chairman James J. Hlawek

Commissioner Leonard McLeod

Commissioner Tom Rankin

Commissioner Kristen Schwenkmeyer

Commissioner Robert B. Steinberg

Commissioner Darrel "Shorty" Thacker

Commissioner Gregory Vach

Commission Members Absent:

Commissioner Gerald O'Hara

Commission staff:

Christine Baker, Executive Officer of the Commission

Call to Order

The meeting was called to order at 10:00 a.m. by Chairman James Hlawek.

Adoption of Minutes

Chairman Hlawek asked for a motion regarding the minutes of the Commission meeting on November 8, 1996, which had been submitted for approval by Christine Baker. Commissioner Thacker moved that the minutes be adopted, Commissioner Rankin seconded, and the motion passed unanimously.

Welcome

Chairman Hlawek welcomed everyone to the Commission's Fact-Finding Hearing on Workers' Compensation Anti-Fraud Activities.

He explained that the purpose of the fact-finding hearing is to bring representatives from California's workers' compensation community together to discuss the workers' compensation anti-fraud activities. The testimony presented will assist CHSWC in identifying issues and determining if legislative and/or administrative changes may be needed to support and improve the effectiveness of anti-fraud activities.

Testimony - CHSWC Fact-Finding Hearing on WC Anti-Fraud Activities

Each speaker was reminded of the fifteen minute limit on presentations. Joe Markey, Chairman of the Fraud Assessment Commission was the first speaker.

Joseph E. Markey, Chairman of the Fraud Assessment Commission:

Mr. Markey reported that approximately $100 million have been collected from employers toward the anti-fraud effort. An additional $10.5 million will be billed in April for a grand total of $110.5 million. By statute, collected money is split 50/50 between the Department of Insurance and district attorneys in the various counties.

Money is distributed between the county district attorneys based on a number of factors including the number of suspected fraudulent claims and the number of employees employed in the various counties. Additionally, each county completes a long application describing how much money it needs and how it will be used. The final factor taken into consideration is the performance of each district

attorney's office - the number of arrests, convictions, and search warrants issued. These factors are evaluated and the county's requested amount is modified by the funds that are available.

This process is performed by a review panel consisting of two Fraud Assessment commissioners, the Administrative Director of the Division of Workers' Compensation, the chief of the Fraud Division of the Department of Insurance or his designee, and a member of the public. The panel then makes a determination and recommendation to the Commissioner who asks for the advice and consent of the Fraud Assessment Commission. It is a laborious process but one that attempts to achieve as much equity as possible.

Mr. Markey stated that many of the concerns that the Fraud Assessment Commission has had in the past about financial procedures and accountability of the anti-fraud effort have been noted. He said that the Fraud Division is on the way toward greater production and performance with the employment of Keith Newman as the deputy commissioner and chief.

Mr. Markey reported that an audit of the Fraud Division was done by the Department of Finance and their findings were submitted to the Insurance Commissioner. He stated that he believes that the Fraud Division has identified the problems addressed in the audit report and are well on the way toward solving them.

Mr. Markey also reported that the Fraud Assessment Commission has been assured that some of the concerns that they have had about the distribution of the resources between the Department of Insurance and the District Attorney are also shared by the Insurance Commissioner.

Commissioner Steinberg asked how the assessment to employers of approximately $25 million per year was arrived at and where the money is going.

Mr. Markey replied that the first assessment in 1992/93 was $10 million. However, with the 50-50 distribution formula previously described, the counties were not getting enough money to fund an effective anti-fraud program so the assessment was increased. He reported that last year the district attorneys asked for $19 million and the Department of Insurance asked for $12.5 million. With the statutory split of 50/50, a base assessment of $25 million was calculated in order to give the Department of Insurance the amount that they needed. The money collected from restitution, fines and penalties was added to the amount given to the District Attorney increasing their share to $14 million. The District Attorneys have indicated that they would like to keep the funding at least at that rate but ideally would like more.

fraud investigation is very steep and very different from other types of insurance fraud investigations.

Mr. Newman reported that Insurance Commissioner Chuck Quackenbush is committed to correcting the problems within the Fraud Division and requested the Peat Marwick Management Company to review the unit and make recommendations. He also requested the Department of Finance audit of the entire Department of Insurance.

As a result, an implementation team formed of internal DOI employees from different disciplines has been formed to work through the changes recommended in the Peat Marwick report, with some oversight and monitoring provided by the Pete Marwick Company at Mr. Newman's request. Mr. Newman stated that changes are now occurring but that the division needs time to improve and effect the changes they have started.

The short term goals of the Fraud Division are as follows:

- Track resources and expenditures
    - Accounting changes have been instituted that will track, by program code, whether an expenditure is workers' compensation and/or auto
    - Changes are being made in the TARS (time activity reporting system) used to track the investigators time
- Timely handling of suspicious fraudulent claims
    - Requiring direct contact with the reporting carriers to determine whether the claims are going to be investigated or placed inactive
    - Coordinating with the district attorneys on the processing of suspected fraudulent claims to avoid duplication of efforts
- Case management
    - Assigning a case number to every suspected fraudulent claim
    - Utilizing a software program that will identify all suspected fraudulent claims involved in major cases. This task is currently done by hand.

- Accountability
    - Investigators, supervisors, and managers will have clearly documented responsibilities and expectations for which they will be held accountable.

Mr. Newman reported that each of the short term goals will be instituted in the Garden Grove office as a pilot program during the months of April and May. On June 1, 1997 the pilot program will be extended to include the other seven field offices. On July 1, 1997 these changes will be implemented in all eight offices.

Mr. Newman also reported that the fraud division has changed the processing of suspected fraudulent claims by making Sacramento a central office in which complaints are received then routed to the appropriate regional office within 24 hours. Within 10 days, the regional office will contact the carrier who filed the claim and make a decision to investigate or place inactive.

Midterm goals of the Fraud Division are as follows:

- Continue with the restructuring efforts as recommended in the Peat Marwick study.

- Add an office of management analysis so that the effectiveness of the teams in different regions can be measured .

- Add a full-time grant coordinator to work directly with the district attorney's offices to audit and oversee the local assistance grants.

- Work with the SIUs (special investigation units) of the insurance carriers on training and auditing their performance since their information is key to investigations.

- Build an internal training program.

- Fill vacant positions. More investigative assistance in field operations is needed

- Expand the work with the district attorneys offices around the state.

Long term goals of the Fraud Division include:

- Technological improvements in order for managers to track individual productivity
- Clean up of the various pieces of legislation that form the insurance fraud and make it standardized

Mr. Newman stated that he fully expects to ask for more money to fund the Fraud Division in the future. Long-term problems and long-term criminal activities, such as insurance fraud, require long-term enforcement efforts and prosecution efforts to deal with them. He cited a case that took five years from the time of investigation until the time a plea was received. Major cases take tremendous amounts of time to prosecute and he stated that he expects to ask for continued funding and perhaps an increase to deal with those problems.

Mr. Newman concluded his presentation by asking the workers' compensation community and CHSWC to allow the Fraud Division enough time to focus on what they are doing with the restructuring and accountability of the Fraud Division.

Commissioner Steinberg expressed concern about the employer community getting "bang for their buck". Since the carriers are now required to have SIUs which initially identify fraudulent activity and the District Attorney is involved in the prosecution of those cases, he questioned the Department of Insurance's role in the process and whether there was enough activity to warrant receiving half of the current funding.

Mr. Newman responded that the SIUs only report what they suspect is a fraudulent claim. It is up to the Department of Insurance to conduct an investigation and present a prosecutable case to the District Attorney. As for whether there is enough work, he said that 6,300 claims were submitted by 170 carriers in an 18 month period from January 1995 to July 1996. If even half of those 6,300 cases were provable, the DOI would be snowed under. Mr. Newman also indicated that most people in the industry believe that the problem is even much more prevalent than the numbers indicate.

Commissioner Vach questioned the coordination and communication between the various district attorneys offices and the Department of Insurance. Mr. Newman replied that initial information provided to him indicates that communication is on a county-to-county basis. However, one of his goals is to increase the coordination and work more cooperatively with a number of counties. He stated that he is a firm believer in the synergy of working together and that will be one of his goals.

Commissioner Vach commented that he would like to see an emphasis on media work to get the message across that anybody in the state that performs workers compensation fraud will be pursued. Mr. Newman agreed stating that there is a need to publicize so that the public is aware that fraud is a continuing problem in our society and that there are adverse consequences of doing it. If it is in the public eye then elected officials become more aware of the problem and are more committed to solving it.

Commissioner Rankin asked to what extent the fraud division focuses on employers who don't carry workers' compensation insurance and solicited his opinion as to whether changes in the law are needed to allow better handling of the problem. Mr. Newman stated that his understanding of the law is that failure to carry insurance is not insurance fraud and therefore no activities by the Department of Insurance are directed toward the problem. However, he said that he could argue that an employer who fails to carry workers' compensation insurance is probably in greater violation than one who misrepresents the numbers of employees and/or other classifications which is considered fraudulent.

[Special Note: Mr. Newman, in a March 26, 1997 letter to CHSWC, provided the following additional information:

"In fiscal year 1995-96 convictions by various jurisdictions, district attorneys and the Fraud Branch totaled 266, bringing the total number to 814 since the beginning of the program in 1992. In the last fiscal year, Fraud Branch investigators spent over 131,000 hours involved in investigations that led to arrests."]

Alice Sprague, California District Attorneys Association

Alice Sprague identified herself as a Deputy District Attorney in Alameda County and Chairperson of the California District Attorneys Association Committee on Insurance Fraud. She stated that insurance fraud is very difficult in comparison to other types of prosecution and expressed concern about consistent support of the program. Because of the length of time required to successfully prosecute the large workers' compensation fraud cases, she said that it is important to have consistent funding from one year to the next. Consistent funding will allow district attorneys to consistently prosecute cases, know what cases they can take on, and keep fraud from reoccurring. If the resources are taken away, the crooks will be back to work performing more fraud. Fraud is a continuing problem which needs a consistent program.

Ms. Sprague also felt that the decline of suspected fraudulent cases from 8,000 to 3,900 this year does not necessarily indicate a 50% reduction in workers' compensation fraud. It might more accurately reflect that carriers with the newly gained knowledge of what makes up a provable case are only reporting those cases that can be proven. And although she does agree that there has been a reduction in workers' compensation fraud, she doesn't believe that it has been by half as the numbers may indicate. She also agreed with Mr. Newman that even if only half of the 3,900 cases were provable, that there are not nearly enough resources to handle them.

Ms. Sprague also said that she did not agree with the Executive Summary assessment that medical mills have been eliminated as a problem. Certainly, they have taken a big hit but treatment fraud has been around for a long time and violators have more probably just shifted their activities to other areas.

Addressing Commissioner Rankin's earlier question about uninsured employers, Ms. Sprague stated that her office sometimes does go after uninsured employers and in fact is currently working on a case. If an employer denies a claim citing other reasons such as the employee was not an employee to cover up being uninsured and it can be established that is a lie then a case can be made of material misrepresentation to deny a legitimate workers' compensation claim. The fact that the employer is uninsured is irrelevant.

Another area they prosecute is premium fraud. Frequently, when a case involves premium fraud there are also EDD violations, such as paying under the table. In those cases, they work together with EDD and charge premium fraud, tax violations, and whatever other crimes may be taking place.

Ms. Sprague stated that there is a real disparity in how uninsured employers are treated in comparison to an individual employee who commits a workers' compensation fraud by making a material misrepresentation. The penalty for an employee is up to five years in state prison and a pretty substantial fine. The penalty for an uninsured employer, however, is only a misdemeanor. Recalling draft legislation of some concern to businesses that called for a $10,000 fine for uninsured employers, Ms. Sprague observed that the amount of the fine was less than the cost of doing honest business.

She said that there are obvious problems in this area but concluded that it would be a mistake to undermine the current funding for workers' compensation fraud and divert it into other areas. Instead, she suggested that CHSWC look into a felony penalty for uninsured employers.

Commissioner Steinberg asked Ms. Sprague where her office receives its caseload. Ms. Sprague responded that she receives some cases from the Department of Insurance. She said that despite some concern expressed about communication between DOI and the District Attorneys, in her experience, the communication is fine. However, there have been some problems because DOI is overloaded and hasn't been able to get all the cases in. She also said that they would like to get advance notice of a suspected fraud case instead of a file after it has been worked up because there may be a problem in prosecution and they could save DOI time and tell them not to bother with the case. She said that she also gets some cases directly from carriers, from Medical Boards, from third party administrators, and from self-insureds which is a problem area because they are not required to have a special investigation unit.

Overall, Ms. Sprague indicated that in the last couple of years most of the cases of suspected fraud have come from SIUs and less from DOI but believes this will change as DOI undergoes policy changes and its new staff is trained.

Commissioner Steinberg asked who investigates the cases of suspected fraud. Ms. Sprague said that she has had cases come in from SIUs which have done an excellent job. but in a perfect world would like to see DOI as the primary investigating agency.

Commissioner Steinberg asked Ms. Sprague to comment on the quality of investigations by both DOI and the SIUs. She replied that some of the best people that she has ever dealt with have been with DOI and would still consider their reports as examples of excellent reports especially from individuals who have been there for some period of time. She said that she has also seen good reports come out of the SIUs.

Commissioner Steinberg asked if Ms. Sprague could provide a breakdown of the different kinds of fraud cases. She said that the numbers vary county-to-county. Los Angeles county gets more of the medical mill cases. A few medical mills are also found in large metropolitan cities in the Bay Area. There are still a few stress cases, but not many. Applicant fraud is still the largest number of cases.

Commissioner Steinberg asked Ms. Sprague's view of the success of criminal prosecutions in workers' compensation fraud and asked if she is hampered by "criminal burden of proof". Ms. Sprague replied that as long as "beyond a reasonable doubt" is the standard, it is always going to be more difficult to prove a criminal case than it is a civil case.

Commissioner Rankin commented that the Commission is talking about introducing legislation which would make it a felony for an employer to willfully

fail to secure workers' compensation insurance. Ms. Sprague stated that she supported the effort. She said that she would also add a fine to it and suggested the Commission look at a state prison sentence as well.

David H. Guthman, Head Deputy, Workers' Compensation Fraud Division, County of Los Angeles

Mr. Guthman is the newly appointed supervisor of the Workers' Compensation Fraud Division of the Los Angeles County District Attorney's office.

Responding to an earlier question regarding the current types of fraud and if they have changed over time, Mr. Guthman stated that claimant fraud or applicant fraud has remained a constant problem throughout the life of the program. Premium fraud has only recently become one of the mandatory reporting categories and he said that he suspects that few insurance carriers report this type of fraud. Rather, they prefer to surcharge their accounts and retain the business. He stated that the mill or the traditional provider fraud has given way to a newer type of fraud, referred to as treatment fraud where the focus is on overcharging or over-utilization. As to the extent of suspected fraud, he stated that contrary to popular belief, it has not gone away. As long as carriers believe it is too expensive to fight fraud and settle out as early and cheaply as possible, it will continue to flourish.

Mr. Guthman stated that there is increased difficulty in detecting suspected fraud. The ingenious schemes and creativity spent on fraud is mind boggling. The statistics accurately show that they have gotten at some of the problem but certainly haven't eliminated it.

Mr. Guthman said that he felt the Peat Marwick study was a very good thing and it identified some good points that are being responded to by DOI. But it has also had some harmful impacts because it perpetuates, as do the regulations under which the funding level is established, an invalid measurement of whether or not the fraud fighting programs are achieving their goal. He said that they are asked for numbers over and over again, how many cases, how many arrests, how many search warrants. If those numbers justify continued funding, they can easily get large numbers of arrests, filed cases, and convictions. But whether or not they're going to have the desired impact is questionable.

The economic impact of a prosecution is not one of the reporting criteria, and yet in one case, they can demonstrate over 9 million dollars in liens that will be dismissed as a result of the conviction. The estimate is ten times as much on auto insurance liens. That one case resulted in a hundred million dollar savings, nine million of that on the workers' compensation side. That one case resulted in savings to

employers or employees that far exceed the cost of running the program in Los Angeles County. But the message of Pete Marwick to DOI investigators is "Do more arrests. Do more search warrants". That means doing the easy cases not the difficult cases. Having been asked what kind mix should be made to capture both mill and simple cases, he has come up with a split of 10 percent mill and 90 percent other types.

As for uninsured employers, Mr. Guthman stated that he believes that they are within the workers' compensation fraud grant because he defines workers' compensation fraud to be illegal conduct that results in a deleterious economic impact. Employers who are uninsured fall precisely into that category. However, if they were asked to prosecute, because it is a misdemeanor, the case would be handled by the Los Angeles City Attorney. He stated that he firmly believes that a criminal sanction does have a deterrent value, and he strongly encourages an effort to convert this statute to a wobbler or an alternative felony/misdemeanor to give the prosecutor or the court the discretion to either charge it as a felony or misdemeanor. Sometimes, an economic sanction alone is not sufficient.

Mr. Guthman concluded by saying that stable funding is essential to the program. Without it, his office could not devote resources to the problem in Los Angeles County. Another problem they have encountered is that because they have to determine what the level of funding will be each year, they find that they are usually five to eight months into the fiscal year before they find out how much money they will receive. By that time, they have often already expended most of the funds.

Commissioner Vach asked why this category of crime should be funded by employer assessments rather than the state General Fund.

Mr. Guthman replied that his understanding is that there was almost a unanimous recognition that there was a problem but also that it was a problem that wasn't going to get funded through general tax revenue. Therefore, the assessment process that is now found in the Insurance Code was established. There are also similar programs in which certain interest groups or "victims" fund an enforcement or prosecution program, such as auto insurance and real estate fraud. So there are lots of instances where the legislature has gone away from the general revenues of the State to victim-funding of enforcement or criminal programs. In this case the decision was made simply because it was the consensus that the funding would not otherwise be available.

Commissioner Vach commented that he agreed with Mr. Guthman's assessment but observed that now there is much more awareness of the significance of workers' compensation fraud and perhaps should be funded by the general revenues.

Mr. Guthman agreed that there is a greater awareness of the problem but noted that fraud cases can be lengthy and generate tons of paperwork. Before the funding, his office was doing a periodic insurance fraud type of case. Now they have 20 attorneys in Los Angeles doing nothing but workers' compensation insurance fraud cases. There is no way they could staff a program at that level from general tax revenues.

Geri Madden, Government Relations Officer, State Compensation Insurance Fund

Ms. Madden stated that the State Fund's concern with fraud is long standing. As early as February of 1990, State Fund took unprecedented action in the history of workers' compensation insurance across the nation and filed a RICO (Racketeer Incident and Corrupt Organization Act) suit in response to an outrageous instance in premium fraud. Not only did they win the case but the United States attorneys office later filed criminal charges based on those same fraudulent acts. The defendants were convicted and punished.

Since then SCIF has continued to be a leader in the fight against workers' compensation fraud. It has created a fraud investigation program which includes the SIU functions as well as the coordination of State Fund's statewide anti-fraud efforts. In addition to the centralized 13-member SIU, State Fund also has a 13-member special litigation unit that attacks fraud through civil litigation and 77 specially trained fraud related members are located in State Fund offices throughout the state. Extensive anti-fraud training is provided to the State Fund organization on fraud identification, investigation and reporting encompassing over 5,000 people. Ms. Madden stated that the State Fund's fraud unit has been and continues to be a very effective weapon in the never-ending battle against fraud.

Donna Gallagher, Manager, Fraud Investigation Program, State Compensation Insurance Fund

Ms. Gallagher reported that a few short years ago that the cost of workers' compensation was so high, businesses were closing and workers were losing their jobs in record numbers. In large part, the high cost of workers' compensation was due to rampant fraud. Blatant and outrageous crimes were being carried out with impunity. So in 1991, in response to this crisis, the Legislature made workers' compensation a felony and created funding mechanisms for the enhanced investigation and prosecution of fraud.

Ms. Gallagher reported that there is evidence that fraud efforts have made a difference, but the war is by no means won. She said that to let our guard down

now would not only be an open invitation to the return of fraud, but would leave a job only partially done. Sharing the results of a recent study of public attitudes about insurance fraud, Ms. Gallagher stated that many Americans believe that certain fraudulent workers' compensation practices are acceptable. She said that these findings reflect what the State Fund is experiencing. Fraud in the workers' compensation system is still alive, well, and living in California. A big dent has been made in the armor, but it is by no means ready to roll over and die.

Ms. Gallagher stated that this study and SCIF's experience cautions against complacency. Many believe that because the battle was fought against the medial/legal mills and made a significant impact, that fraud has been eliminated. But in reality, the criminals are just using new tactics to exploit the system. There is too much money to be made for them to give up so easily. Also, most of the big successes to date have been with the blatant offenders. There are many more subtle approaches yet to be caught.

Looking at the kinds of fraud that SCIF is seeing today, Ms. Gallagher reported that the categories of fraud are the same ones which have always tormented the industry. Fraud is perpetrated by workers, doctors, lawyers, employers, and anyone who deals with the system as a recipient of benefits, a payer of premium or a provider of service. There is no shortage of people who are willing to give fraud a try, and there is no part in the workers' compensation process that is immune.

Ms. Gallagher stated that combating claimant fraud must remain one of the focuses of our efforts. Although the loss per case in claimant fraud tends to be smaller, they nonetheless cost the industry a great deal of time and money and are a continuous source of aggravation and high costs for many of the employers of this State. Ms. Gallagher stated that while we will never be able to stop the crime completely, we must create a deterrent by catching as many as possible and publicizing the results.

Medical fraud, like claimant fraud, she reported, presents its own unique set of challenges. Treatment-related frauds have plagued the health care industry for years. The types of treatment fraud seen in the health care industry are: billing for services and procedures and/or supplies that were not provided, intentional misrepresentation of the services provided, and deliberate performance of unwarranted nonmedically necessary services for the purpose of financial gain. Recent changes in our workers' compensation laws have given the designated treating doctor unprecedented levels of authority and autonomy in controlling the type and duration of medical treatment resulting is an open invitation to the unscrupulous medical providers who are bent on committing fraud. Ms. Gallagher estimated that despite SCIF's understanding of these types of frauds and putting for their best effort to combat the problem they estimate that they could have paid over

$15 million for fraudulent medical treatment in 1996; and SCIF represents only 20 percent of the total insured market.

Ms. Gallagher stated that another destructive and cost driving type of fraud is premium fraud. The under-reporting of payroll and misclassifying of employees to a lower rated classification in order to pay lower premium has been going on for years and continues today. Premium fraud hurts honest employers in three ways. First, it gives the appearance that there are higher than expected losses when compared to payroll or job classification, thus causing the rates to go up. Secondly, even if an employer has failed to pay their fair share of premium, their injured employees are taken care of at the expense of honest employers. Lastly, honest employers lose competitiveness in the marketplace when dishonest employers, by virtue of having lower insurance costs, have lower overhead and allows them to underbid honest competitors and driving them out of business.

In order to fight these types of fraud, Ms. Gallagher stated that potential offenders need to be continually reminded that they are being watched and the offenders need to know that they will be punished. She said that we must also recognize that the face of fraud is ever changing. Vigilance and hard work are a necessity if we are to continue to make progress against fraud. New approaches to fraud are always taking the place of those that are defeated. Without continued efforts, we will quickly be overwhelmed by new schemes whose faces have yet to be discovered.

Ms. Gallagher concluded by stating that State Fund will remain steadfast in its commitment to fight fraud. She said it is their fervent belief that all these efforts must continue and she hopes the Commission agrees.

Commissioner Schwenkmeyer asked Ms. Gallagher how SCIF decides which cases of suspected fraudulent claims will be followed up and which will be settled because it may cheaper and easier to do so.

Ms. Gallagher replied that SCIF makes value judgments based on each case. In some cases it is evident that the prosecutor would want to go forward with it. There are other cases that may be very difficult to establish the necessary evidence to prove fraud in a court of law. There have been about 172 felony arrests on State Fund reported cases since its inception to the program of which 85 have been convicted.

Commissioner Thacker asked if it was Ms. Gallagher's perception that a great deal of medical liens are filed by people either in past practice or currently associated with the medical/legal mills. She replied affirmatively. He then asked if she thought that a lien process which specifically targets those people who have already been identified either through the DOI or DA tracking system could be fast-tracked into some resolution. She replied that there is some difficulty with that process. There

have been some recent trends in the industry where it was attempted to consolidate outstanding liens on those particular people where criminal complaints have been filed and hold them up pending the resolution of the criminal case. But a WCAB decision no longer allows that practice and they must go forward on the individual cases.

Commissioner Rankin asked if other insurance companies have taken actions similar to SCIF's RICO and civil suits against companies for premium fraud. She replied that she was not aware of other carriers taking legal actions.

George Lively, Contractor

Mr. Lively stated that he is a small building contractor whose business is primarily residential construction. He stated that circumvention of the rules is the biggest problem he has in staying competitive in the market. The severity of the problem has led to the destabilization of the market value of the construction work and consequently, the labor. The circumvention of workers' compensation rules is only one factor casting the shadow. Circumvention of state and federal payroll taxes, licenses, building permits, and liability insurance are some of the other factors that make the cost differential enormous. He stated that prosperity in his industry is more likely coming from doing what you can get away with. The average company is prepared to pay the penalty if they are caught circumventing the law. He said that the true problem lies with too many rules and too much associated expense. Those who do understand the laws feel helpless to do what's right because they can't compete.

Mr. Lively stated that many of the enforcement procedures in existence have been developed with some wrong assumptions. People who are in the system are being targeted when the true target should be people who are out of the system. A lot of time is being spent correcting a small portion of the industry.

He said that the local building permit requirements are often not sufficiently enforced. There's a huge work force in remodeling and installing section units without a building permit and property owners often prefer not having a permit. There may be consequences for the property owner or contractor but the risks are calculated against the tremendous savings. Without permits, these contractors are invisible. Oftentimes, spousal health insurance and property insurance replaces all of an honest employer's workers' compensation, liability, and health care insurance.

Another problem is that a licensed contractor, who is legally exempt from carrying workers' compensation because he has no employees, often hires subcontractors who also have no insurance, as a way of circumventing the system. These

employees are not responsible for the work so technically they are not independent contractors, they are employees, but the Contractor's Board considers them legitimate subcontractors. No one is going to investigate these kinds of cases. They will go undetected until someone is hurt badly.

He stated that the biggest losers in the system are the workers and taxpayers of tomorrow because many construction workers have no social security, unemployment, workers' compensation insurance, health care, or pensions, and sooner or later they are going to get sick or injured. It is going to be their spouse's insurance, Medicaid or some other program that will take care of them when they can no longer earn money underground.

Mr. Lively stated that CHSWC is best situated to make some important changes in enforcement opportunities. He said there must be a compassionate understanding of the entire problem as well as a willingness to be harsh in solving the problem. Mr. Lively stated that the key ingredient is educating all employers and workers about the law through the media or perhaps a pamphlet distributed by building inspectors so that property owners, Realtors and insurance people understand the laws that they are violating. He said that more field visits are a necessity.

Commissioner Vach asked what Mr. Lively's overhead was and his workers compensation premium per month. Mr. Lively replied that his cost for a carpenter is $42 per hour. He said that he can compete with someone who doesn't have insurance or health insurance but cannot compete with an independent contractor who only charges $15 an hour. Most homeowners know it is wrong to hire these unlicensed contractors but aren't clear how serious it is. He said he is convinced that the average consumer would much rather take a chance than pay the additional money. He reported that his workers' compensation premium is 10 percent of the actual gross payroll and as such is better than most because he has no claims against him.

In response to Commissioner Steinberg's request for clarification regarding the difference in cost between the $42 per hour he charges compared to the $15 per hour charged by an independent contractor, Mr. Lively stated that his union contractor makes $25 an hour and his take home pay is $650 to $700 a week. The rest of the $42 per hour comes from social security, unemployment, insurance, health insurance, and workers' compensation payments. The homeowner who doesn't have these expenses can hire that same carpenter for $18 per hour and the carpenter would bring home the same amount of money. He said it is important to let the homeowner know that it is not worth the risk.

Commissioner Steinberg stated that in order to address the problem it must be attacked at the property owner level. Mr. Lively agreed stating that he has seen time

and again a property owner building one to three houses a year, staying out of the public record as much as possible and hiring local workers, not reporting them, not complaining about anything and making a living building those houses.

Commissioner Vach asked if there was a mechanism within the building material supply industry to correct the problems indicated. Mr. Lively stated that he didn't see it. Permits can be checked and material followed home, but he didn't see how you can find out from the supplier who is buying it and where it is going.

Edward C. Woodward, California Workers' Compensation Institute

Mr. Woodward stated that since the implementation of the fraud statutes, the system has changed rather dramatically. The system has gone from $9 billion in premium in 1993 to $5.1 billion in 1995, a 43% drop. That drop has been attributed to a number of factors including the unrelenting rate war among carriers. However, workers' compensation "incurred costs" dropped from $6.8 billion in 1991 at its peak to the 1995 accident year of $3.9 billion, also a 43% drop. What is driving a lot of the change is subject to a lot of speculation. But the one thing that known for sure is that there has been a dramatic decline in the frequency of claims in the workers' compensation system. At its height in 1991, insureds were reporting over 140 claims per million dollars in payroll. In 1996, that number is 84.7 claims per million dollars of payroll, a decline of 40%. Indemnity claims are at a record low, the lowest recorded since 1988.

Besides the absolute drop in premium, losses, and frequency, there's also a reason to believe that some of the factors that directly contributed to fraud have also been declining rather dramatically. One of these areas is the number of mental stress claims which were often the vehicle for fraudulent operators because the claims were so easy to effect. From 1991 to 1994 there was a drop of 65%.

Another factor is the medical mills and problems with unconstrained costs. The average cost of a forensic report at its height in 1992 was about $1,100 per report with an average of 2 to 3 reports per litigated case. CWCI has completed a study, not yet published, on medical/legal costs that shows that the cost of a report has gone down to $577, a 47% decrease. Additionally, the number of reports per case have decreased to 1.6 reports, a 30% reduction.

Mr. Woodward stated that he felt it was safe to say that from when the fraud statutes were effected, the system has undergone rather dramatic changes, both in terms of its costs, number of claims, those things that are driving costs, those particular areas that relate to and contributed to a lot of the fraud. In surveying its members, the Institute found that there have been over 17,000 referrals of suspected fraudulent

claims by insureds to the appropriate agencies from 1992 through the third quarter of 1996. These referrals were higher the first year but leveled off to approximately 1000 referrals per quarter.

When this is studied on an adjusted market share basis, it is discovered that the relative rate of referral has not changed. At this point, the rate of referrals is approximately 10.4 per 1% of market share. Over the last few years, it has ranged anywhere from 10.4 up to 14 per 1% of market share. So it's a relatively static rate.

There is an average of 65 arrests per quarter. It bounces around from quarter to quarter but on a market share basis shows the same relatively flat line.

Since 1994 there have been 305 convictions. The number had been on a quarterly average of approximately 20 to 25. During 1996, that number has dramatically increased to about 45 convictions a quarter. So convictions are also increasing and remaining stable. On a market share basis, it's about half a conviction per million dollars of premium on average.

Mr. Woodward stated that after reviewing the statistics that if we were to assume that the level of fraud were consistently remaining constant in absolute levels, the amount of people committing fraud would have to have increased somewhere around five or six times in order to maintain the types of same level of fraud on a relative basis.

Mr. Woodward submitted the statistics for the record and read a prepared summary about case law that has impacted the abilities to fight fraud. He emphasized that the Institute doesn't necessarily quarrel or disagree with the decisions of the WCAB; many of them are well reasoned but the impact is to reduce the number of tools with which to effectively fight fraud.

The Court of Appeals has recently reaffirmed the exclusive jurisdiction of the WCAB even in the area of fraud. Decisions limiting discovery, including restitution, easing of civil penalties for criminal fraud convictions and limiting introduction of evidence of fraud and workers' compensation reviews, all mitigate against the vigorous enforcement of the anti-fraud measures. Mr. Woodward expressed the opinion that those who aggressively pursue fraud and abuse of the system now bear not only the cost of the investigation and prosecution of the fraud action but also the secondary backlash litigation which is very costly.

Mr. Woodward concluded by talking about the last five or six years of the Fraud Assessment fund. He said that he found it interesting that six years and a hundred million dollars later that basic management and fiscal controls are being put in place over the resources. This is not a new problem. He said that he sent a letter to the

Fraud Assessment Commission five years ago outlining the problem and making a series of recommendations for establishing credibility. Mr. Woodward stated that there is a structural flaw in the way the fund is organized. The Fraud Assessment Commission sets the assessment rate and has the power to set the overall level of money, but are constrained by an arbitrary percentage. They also don't seem to have the staff or authority to be able to effectively demand accountability without which we are going to continue to experience problems in the operational aspect of fighting fraud. He said that his purpose it not to point fingers but believes there is a structural problem in the legislation and the way it is organized that really should be addressed ultimately for everyone's benefit.

John Benson, Vice President of Claims, Zenith Insurance

Commissioner Steinberg stated that he was concerned about the large amount of money being assessed and although the Fraud Assessment Commission is coming together shares the industry's concern about sufficient bang for the buck. He asked for clarification about the jurisdictional areas of the Department of Insurance, the SIUs and the local District Attorneys. He also asked for Mr. Benson's view of how the system is working and any problems that the Commission can help correct.

Mr. Benson stated that it has been his experience that there are quite a few problems. He stated that Zenith Insurance reported 10 to 12 percent of its investigated cases to the Department of Insurance and DAs offices as required by law. Mr. Benson reported that his unit has seen very little response from the Department of Insurance in terms of investigation. If a case is investigated, it has taken an extraordinary amount of time and duplicates a lot of the efforts already taken by Zenith investigators. Zenith investigators, who are well trained in dealing with fraud cases, do an investigation and prepare a prosecution summary which is then turned over to DOI and the DA which often redo the investigations. So essentially, there are three different bodies performing the same investigation.

While there are some reasons to do that in terms of prosecuting a case, Mr. Benson stated that it doesn't need to be done that way all of the time. There are District Attorneys who take Zenith's prosecution summary and file a case within a week after it is submitted. Meanwhile, the Department of Insurance takes two years to do an investigation of the same case.

Commissioner Steinberg asked if there is a system that Mr. Benson could recommend that would come with better fixed responsibilities for the process of getting suspected fraud from its inception to the DA or others.

Mr. Benson replied that he thought the carriers were the front-line where fraud should be reported through an 800 number such as that used by Zenith Insurance and SCIF. Once the fraud is reported, he said that it is the obligation of the carrier to do an initial investigation to determine whether or not there is a prosecutable case. He said that he would prefer to not see multiple investigations occurring on the same case and would like to see more money go to the DAs and less money to the Department of Insurance. The Department of Insurance need only be involved in cases such as those dealing with fraud with multiple jurisdictions, or medical-mills. He said that a task-force approach would be much more efficient than what is currently in place.

Commissioner Steinberg asked about the breakdown of the types of fraud Zenith's SIU was working on and reporting to the DAs.

Mr. Benson replied that the majority of cases are applicant cases because most insureds are most concerned about their particular fraud case within their company. However, they do have some larger employers who are concerned with the cappers, vendors, medical providers, and specifically the chiropractors and physicians. There are a large number of those kinds of cases as well. There are also some premium fraud cases. He stated that three quarters of all cases are claim fraud which typically is an injury that did not occur in the workplace but was reported as a work related injury or is an exaggerated injury.

Commissioner Steinberg asked if fraudulent claims that appear before the WCAB result in a "take nothing" award.

Mr. Benson reported that he wished that were the case but has had several instances where there were felony convictions for insurance fraud but the WCAB still awarded benefits to the applicant. Mr. Woodward stated that in Washington there was a case that said that if there is fraud in a case, only the species and benefits in which there was fraud can be withheld.

Mr. Benson stated that the exclusive remedy case where the Court of Appeals said that the WCAB is the exclusive remedy deals with a medical provider case. Up until that case, there were many civil cases against provider fraud and virtually everyone believed it legitimate. But this case has shut that practice down. However, in premium fraud cases civil suits can be filed and exclusive remedy is not an issue.

Commissioner Rankin asked if the exclusive remedy case precludes the type of civil RICO suits that were filed in the early nineties. Mr. Benson said yes and stated that there is another case where a medical provider sued a number of insurance carriers which believed this particular medical provider was suspicious and therefore dealt

with their liens very aggressively. The provider felt that the carriers got together and put him out of business so they sued the carriers. Some of the carriers filed countersuits and it is believed that those and the original lawsuit will be dismissed based on exclusive remedy. Mr. Woodward commented that having the WCAB as the exclusive remedy isn't a very significant deterrent so the previous policy was to allow any civil actions related to fraud.

Commissioner Steinberg commented that if the exclusive remedy case is not further appealed and remains final it will create a situation where any type of civil remedy in the fraud area would now fall within WCAB jurisdiction and might be an area for CHSWC to further explore and make some recommendations. Mr. Woodward commented that the New Jersey anti-fraud statutes are basically all civil in nature and have been successful in collecting a great deal of money from those who have committed fraud within the workers' compensation system. He offered to provide the Commission with a copy of those statutes for review.

Julianne Broyles, California Chamber of Commerce

Ms. Broyles stated that she was representing the Chamber of Commerce and Willie Washington of the California Manufacturers Association who was unable to attend.

She stated that she has heard conflicting reports on how effectively different sections of the fraud program have been using the employer assessed fraud funds. She said that employers are fiscally conservative and would like to see results for the one hundred and ten million dollars spent toward the fraud effort. Employers were told that they would see results and therefore she was surprised to hear Mr. Woodward state that things are actually remaining the same. There have been 561 arrests and 305 convictions in the several years the program has been in effect, all for one hundred and ten million dollars. She commented that she would like to see a breakdown of what that ends up costing per actual conviction. Commissioner Vach replied that it is approximately $360,000 per conviction.

Ms. Broyles said that she believes the intention of the fraud program is a very good one. It is known that if an employee is caught and successfully prosecuted for committing a crime in the workplace, it deters similar crimes for many years. The employers' concern is that they are being told that the District Attorneys office and Department of Insurance want the money on their own terms and there is no indication that the demand for the money is being reduced. She said that she was glad to hear Mr. Markey state that the demand would stay at $25 million for at least another year because after seeing the report that was done by the Department of Finance on the use of the money by the Department of Insurance, they have had serious concerns.

Ms. Broyles said that the Chamber is concerned that the money is not being used in the area that it is being asked for. Because of the way the funding mechanism is set up with a 50/50 split, the money cannot go to where it is actually needed. She said that the attorney general's office is also able to request the funds and she hasn't heard any information about them coming in and asking for money.

She said that the main point she would like to make is that the employer community is very concerned about the inadequate accounting of the use of the funds by both the district attorneys and the Department of Insurance. She suggested utilizing a standardized report to be filed at regular intervals stating how the money is being used.

Another concern is the inflexibility of the funding formula. She said that there is draft legislation set to go this year which allows the Fraud Assessment Commission to appropriate up to 60 percent of their funds to the Bureau of Fraudulent Claims of the Department of Insurance and at least 50 percent of the fund shall be distributed to district attorneys. This legislation is to provide money to an area that the employers feel is doing more of the serious prosecution and combating of fraud at this time.

She concluded by stating that she would like to see a more global view and attack on workers' compensation fraud rather than focusing on one portion.

Commissioner Rankin asked how Ms. Broyles would feel about using some of the fraud money to deal with the problem of uninsured employers. She responded that she would have to look at proposed language before she could make that determination. She stated that she wasn't sure if it is appropriate to concentrate just on the workers' compensation area when there are many other areas of where employers operate illegally, putting honest employers at a competitive disadvantage.

She said that she would be interested in talking about areas such as the flexibility in the funding formula, protection for employers to report fraud outside of their carriers, and training of employers and employees in smaller counties on the spotting and prevention of workers' compensation fraud who would like to band together and make a grant application.

Ms. Broyles concluded by stating that there are a lot of issues that can be brought to the table and that the employer community wants to be part of the discussion.

Esther Santiago, Industrial Safety and Risk Management Group

A written statement was submitted for the record and distributed to the Commissioners. Ms. Santiago expressed concern that "attorneys are very innovative and look at different methods of going after employers for lucrative gain. She described a situation that she terms a different method of suspected fraud in workers' compensation. An applicant is claiming serious neglect in a civil suit against the school district utilizing a separate and unrelated workers' compensation injury to another teacher to substantiate her claim. A second employee suffered an occupational injury which resulted in an investigation by Cal-OSHA, including interviews of other employees, including the first employee. Cal-OSHA subsequently issued an alleged "serious citation". The district filed an appeal and met informally with Cal-OSHA and disposed of the "serious" citation. However, the attorney for the first employee "jumped on this case" and is using the alleged "serious" citation as proof that the district had acted in a serious and negligent manner in the civil lawsuit against the school district.

Mark J. Gerlach, Consultant, California Applicant's Attorneys Association (CAAA)

Mr. Gerlach stated that CAAA has worked closely with all parties in the legislature to work on the fraud problem. He said that one issue that needs to be looked at is where the fraud is occurring. He said that a study he is aware of done by the State Fund in Colorado found that employer fraud, primarily the under-reporting of payroll, was twice as prevalent as employee fraud. However, most of the prosecution and investigation is on the claimant. He stated that this may not be where the problem lies and recommended that it be looked into.

Secondly, he stated that we need to find out what the economic consequences are fraud and its prosecution so that we can get a sense of where it is affecting the system the most. There have been a handful of medical mills causing hundreds of millions of dollars in problems. There have been prosecutions of 271 claimants in which the savings to the workers' compensation is nowhere near the hundreds of millions of dollars saved by getting those medical mills out of the system. He said that he thinks that we will find that fraud is affecting the system the most in areas such as provider fraud and employer fraud. There is too much emphasis on easy claimant fraud which is easy to catch and easy to prosecute. He said that if we are going to use $25 million a year wisely, we should use it in the areas in which we can have the most effect on the system.

Mr. Gerlach concluded by stating that he doesn't think there is any question about whether or not uninsured employers are committing fraud under the Fraud Prevention Act. In 1995, Section 1871, the lead section to the Insurance Fraud

Prevention Act, talks about the actions of employers who fraudulently under report payroll or who fail to report payroll for all employees to their insurance company and states that the failure to report all payroll is an uninsured employer. He stated that one of the areas that we should be looking at in enforcement of anti-fraud efforts and the spending of the money received from the Fraud Assessment Commission is uninsured employers.

Commissioner Vach stated that fraud is a very broad concept for the public. There are employers who are concerned about a fraudulent claim, but it doesn't meet the Insurance Code definition of fraud. He asked if perhaps we are looking at fraud at a level lower than the Insurance Code definition. Lloyd B. Rowe, of the Law Offices of Posinoff & Rowe responded that the Insurance Code states that certain activities shall be considered fraudulent but fraud per se is not defined in these particular code sections. Commissioner Vach stated that the point he was trying to make is that fraud is at a level from black and white to gray and when we restrict ourselves to defining what a fraud problem is, maybe what we're really looking at is a much broader spectrum of activity which, while potentially not illegal as defined it nonetheless questionable.

Uros Jelicic, Injured Worker

Mr. Jelicic expressed the opinion that the workers' compensation system is a business for profit. Many proceedings, especially at a higher level, disregard the law. The DWC Administrative Director is supposed to report every three months what is going on, but he never makes that report to the government. Casey Young makes more effort to stop, rather than assist, payments to injured workers. Most fraud comes from within the system.

Closing Remarks

Commissioner Vach, who had anticipated IMC's participation in the hearing, requested that the record be kept open to incorporate their response to written questions having to do with overbilling, bundling of fees, and medical/legal charges.

Commissioner Rankin asked Mr. Newman back to address some follow-up questions about funding. He asked him where the $2.5 million in fines and civil penalties goes and who collects it. Mr. Newman replied that the $2.5 million was distributed to the District Attorneys. In response to a question as to who collects it, Alice Sprague stated that the fine from the capital case in Los Angeles was collected by Los Angeles and then delivered to the fraud fund through the Department of

Insurance. Essentially all money ends up going through the Department of Insurance to be put in the fund.

Other Business

Permanent Disability Schedule

Commissioner McLeod suggested that, because the Commission has an obligation under Labor Code Section 4660(d) to approve any "change in the standard disability ratings" before they may be adopted by the DWC Administrative Director, that it get a legal opinion as to whether the recent revision to the Permanent Disability Schedule contains such changes. Secondly, he suggested that the Commission contact Mr. Young to find out what his reasons were for changing the schedule without approval of the Commission and, if legal counsel determines that changes to the standard disability ratings were made, ask him to hold off on the effective date of those changes.

Christine Baker stated that Casey Young is scheduled to appear at the April 24th meeting of CHSWC in Sacramento to discuss the revision of the permanent disability schedule.

Commissioner Steinberg stated that he recalled Mr. Young took the position that the promulgated changes were not the kind of changes over which the Commission had jurisdiction. Ms. Baker agreed that this was Mr. Casey's position. She stated that if the PDRS is adopted, the changes will go into effect April 1, 1997. Chairman Hlawek requested that the Executive Officer make the inquiry as suggested by Commissioner McLeod.

Carve Out Study

Commissioner Vach stated that he has recently become aware of the objection to procedures in the carve out study by a special interest group and that he is confident Christine Baker will address those concerns. However, he said that he is concerned that every time the Commission comes up with a study or methodology that someone doesn't like it will have to go through the same dance in order to do what it believes is appropriate.

The Commission is employing legitimate, third party, independent, study firms with extraordinarily good reputations and the fact that some of the sources of

funding may come from outside the Commission seems irrelevant to the effects of the investigation. He stated that he finds it personally offensive that that kind of activity is being carried out by a group that pledges to be a friend of the injured worker when the Commission is only trying to find out what is best for all parties. He said that bringing the Commission to a level of suspicion about the sources of funding for the carve out study puts the Commission's efforts on the defense when the Commission is the one body in all of California's workers' compensation system that has at least a modicum of respect for the truth.

Chairman Hlawek stated that the Commission has tried to fashion a nonpartisan path of looking at workers' compensation and believes it has been successful in doing so. He acknowledged that in its attempt the Commission will offend people at times, step on their toes, and go into areas that have not been looked at in the past. The fact of the matter is that the Commission will be criticized by one group or another because it will look at areas that are not favorable to one group or another, but that is part of the Commission's charge. As long as the Commission feels that it is acting in an appropriate manner without any bias, then it will continue. He said that commission staff has been put in an awkward position of being asked to delay studies approved by Commissioners but if a study has been approved by the Commission and receives no outstanding reason to discontinue it, the study shall proceed.

Commissioner Steinberg stated that there were two points that were raised regarding the carve out study. First, there was the question about the source of funding for the study. He said that when the study was approved the Commission was concerned that it be fashioned in a way to avoid criticism for its funding. Despite the fact that the majority of the study is funded by an outside source, the Commission was satisfied that this objective was accomplished.

Secondly, he said that he raised a question about the constitutional issue involved in the carve out process and was satisfactorily assured that it is an issue that will be addressed in the study itself.

He stated that he feels that the study can proceed now that these issues have been flagged.

Future Meetings

The next meeting of the Commission will be held Thursday, April 24, 1997 at 10 a.m. in the Auditorium in the Secretary of State Building at 1500 11th Street in Sacramento.

Adjournment

The meeting was adjourned at 2:13 p.m. by Chairman Hlawek.

Approved: Respectfully submitted,

Christine Baker for James Hlawek — Christine Baker

James J. Hlawek, Chairman Date 4/28/97 Christine Baker, Executive Officer